Nursing Facility Self-Reporting
Abuse Allegation Form

Please complete this form and Fax to the Certification Bureau 406/444-3456 or call 406/444-2099

This form has been developed and revised 5/2007 at the request of Montana Long Term Care facility staff. This is not a State or Federally required reporting form. You may modify and/or develop your own reporting tool to assist your facility in the compliance of F223-F226. The completed form may be sent to DPHHS, Quality Assurance Division, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, MT 59620-2953.

Facility:_____City:_____

Accused Persons Name:_____Title:_____

The name of the resident(s) alleged to have been abused:_____

_____

Date of the Incident:_____Date Incident was Reported:_____

Name of the Investigator(s) and Title(s):_____

Date investigation initiated:_____ Date investigation completed:_____

Describe what injury the resident received in each category applicable:

Verbal/Mental	
Physical Injury	
Sexual	
Theft	
Incident of unknown origin	
Neglect	
Other (describe)	

List the names of all persons interviewed (staff, resident(s), families…) as well as their phone numbers and addresses (use the back of this page or add attachments if faxing this information):

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Describe the incident beginning shortly before the alleged abuse occurred and ending shortly after. Each witness should provide a statement on a separate piece of paper, and the investigators combined information should be reported here as a short summary.

At the time of the allegation was reported what protective action did you utilize to prevent further abuse to resident(s) of your facility?

It is the investigator(s) conclusion that abuse_____(did or did not occur).
As a result of this investigation the following actions have been taken:

Signed and Dated by:_____Title:_____Date_____
Print Name:_____